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ABSTRACT

When the psychologist serves Head Start, he must be a consultant to the whole Head Start organization, from top to bottom, director to children, and horizontally from potentially supportive agencies in the community to the Head Start staff, to the children and their parents. In the process of serving as a community psychologist, he will be called on to perform traditional clinical services as well. If there are not enough psychologists who are willing to accept these new roles and responsibilities, then new psychologists must be trained to accept this challenge in clinical child psychology, since the present programs do not reach the disadvantaged child. (KJ/Author)

Providing Direct Service and Preventive Programs for Children in Poverty[1]

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I. An Overview and the Problem

Traditional direct services for the emotionally disturbed child have generally failed to reach economically disadvantaged families. Two recent socio-political developments offered some promise to correct this problem: The anti-poverty programs with many mental health-related components directed to children, notably, Head Start, and the community mental health programs, which also seemed uniquely suited both to fill gaps in direct service in poverty areas and to mount preventive programs. Illustrative examples of Head Start psychological services are used to evaluate progress over the last five years, and some promising new models are discussed.

By "community psychology" or "community mental health" program, I mean a program which offers both direct services for current emotional or behavioral difficulties, and those services aimed at the prevention of future emotional problems. Psychological or mental health services for all children is a large component of any community psychology program. However, economically disadvantaged children require special attention because they will probably not be helped by typical programs now in existence. Direct services for current problems of children at the present time are provided by out-patient child guidance clinics, which for the most part are suited to serve a middle-class rather than a lower-economic-class clientele (Adams and McDonald, 1968).

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[1]Paper presented as part of the Section I, Division 12 Symposium, "New Directions for Clinical Child Psychology," at the annual meeting of the American Psychological Association, Miami Beach, September, 1970.

In providing preventive programs, community psychology offers the promise of a breakthrough in the attempt to reach economically disadvantaged children. Disappointingly, the promise has not yet been fulfilled. There are several reasons which account for this.

First, our society has not devoted the resources necessary to make headway on the immense task. There are a few exceptions, but by and large, federal, state, and local governments have not allocated sufficient money to really try the new community psychology concepts. To do this, the nation must shift its priorities, replacing the Indo-china war and the limitless drain of the national talent and resources on military technocracies, with items of pro-human and pro-survival value. Ecological, educational, and community psychology programs would be examples of the latter.

Individuals and professional organizations must speak out against the lunacy of military plunder--the indiscriminate destruction of life right up to our own shores. Budgets of domestic programs, like NIMH, as all of you know, suffer wicked cuts while military expenditures sail merrily through congressional committees, often escalating enroute. On the bright side, however, organizations like the American Orthopsychiatric Association found the courage to come to grips with the fundamental issue of reordering national priorities in its recent position statement to the Joint Commission of the Mental Health of Children (American Orthopsychiatric Association, 1969). Can our organization be far behind? I hope not.

A second reason why community psychology programs, as such, have not provided necessary services for disadvantaged children may be that there has not been sufficient time for the development of these services. Certainly, there have not been high quality community psychology programs of sufficient breadth, in action a sufficiently long period (say, 15 or 20 years) to demonstrate even by

comparative case example the potentials of the program, let alone to provide systematic scientific research evidence on these methods.

On the other hand, is such evidence--at least a generation away--really necessary? I think not. In Project Head Start, which was an exception to the general inaction, the government mounted a massive new program for the educational welfare of economically deprived children. This proceeded from a substantial, though not everwhelming research basis. Indeed, Head Start's justification from research evidence is still not clear. For instance, the Westinghouse-Ohio Project's evaluation of Head Start is being currently debated (Harvard Education Review, 1970)

In community psychology there is probably now available a body of demonstration projects and firm research evidence, piecemeal and limited though these may be, that is comparable to that available to Head Start organizers when it made its debute.

The general purpose of the present paper is survey the field and to examine in detail a promising delivery system for community psychology in which psychologists have been, or should have been already involved. However, in the interest of time this morning, I'll limit the scope of this survey to the preschool period of childhood. Thus, I am excluding consideration of certain very important and promising programs which may deliver community psychology services to economically disadvantaged infants, preadolescents, and adolescents, including the anti-poverty (Office of Economic Opportunity) programs, such as the Neighborhood Youth Corps and Upward Bound; programs for preventing for youth employment, and delinquency, for unwed mothers; and, ripe with potential, comprehensive health care programs. Nevertheless, there are many parallels, I believe, between the creative and effective roles of a community psychologist in these programs, and the psychologist's roles in Head Start which I will describe in detail.

In what follows, I shall concentrate my attention on Head Start. There are several reasons for this focus. As a new program, Head Start was not as limited to old patterns as established institutions were. Thus, there was, and perhaps still is, a good potential for innovation. Secondly, Head Start reaches children at a critical transition point in their life--when they are crossing the threshold from life in the family to life in society, the public school. Under the stress of such a transition, many emotional crises might be anticipated. Thirdly, Head Start is no mere demonstration program, but a large scale endeavor currently reaching hundreds of thousands of preschool children. Fourthly, Head Start has an officially defined role for the psychologist (Office of Economic Opportunity, 1967) which is highly compatible with the innovative consulting role of the community psychologist.

II. Review of Published Reports

Due to time, this morning it is not possible to review the growing amount of relevant basic research, Head Start reports, and descriptions of community mental health programs for the disadvantaged. The topics in this area include:

A. Basic research

1. Child development and psychopathology
2. Family dynamics
3. Descriptive studies of the economically disadvantaged

b. Head Start

1. Background studies and early justification (Hunt, White, Bronfenbrenner
2. Program description, educational component
3. Program evaluation, educational component (Harvard Education Review, 19
4. Parent involvement and social services component
5. Psychological services component
6. Related programs: Follow Through and Parent and Child Centers

C. Other Programs

1. Comprehensive Health Care programs
2. Infancy programs
3. Other education programs
4. Other community psychology or community mental health programs

There are a substantial number of public reports in each of these 13 sub-areas with one exception. To my knowledge, there are no public reports, either written or presented, of psychological services in Head Start. Thus, this is the area which I shall now discuss.

III. Psychological Services in Head Start: Types of Problems Encountered

Over the last five years, I have worked in a variety of roles with ten different Head Start programs located in six different states. Hence, my observations are limited. However, certain patterns have regularly recurred and certain situations have been common to all programs. Thus, I am fairly confident of these generalizations, limited in scope though they may be. Furthermore, another qualifying factor to bear in mind is that last year Head Start was moved from the Office of Economic Opportunity to the new Office of Child Development in the Department of Health, Education, and Welfare. The Office of Child Development's new Director, Professor Edward Zigler, may change and innovate Head Start in ways that will undercut and make obsolete such problems as I shall describe.

My optimism, however, must be guarded. The day before yesterday, one of our Miami's two Head Start programs was closed down, sending 1,000 preschool children back into the streets. The specific reasons are complex. Last week the Miami newspapers reported that the HEW Southeast regional office suggested that to help save $471,000 cut from Miami Head Start's budget for the coming year, without cutting about 500 children, certain economy moves be made, including reducing the number of psychologists from two to one. Even two psychologists is below the staff level which is officially prescribed by the Head Start Manual (Office of Economic Opportunity, 1967).

For those of you not familiar with the Head Start Manual, it states the

following as official Head Start guidelines and requirements for psychological services:

"The Psychological Services Program:

"Every Head Start Program must have a psychological services program that facilitates effective interaction among staff, parents, children, and volunteers.

"The psychologist has important contributions to make in all phases of a Head Start Program. His major role should be that of enabling staff, parents, children, and volunteers to relate to one another effectively to maximize benefits of the program. In order to do this, his functions should include:

(1) Consultation with staff concerning needs for diagnostic evaluation of individual children;
(2) Arrangement of and follow-up on evaluation;
(3) Consultation with teachers and aides concerning diagnosed needs of individual children;
(4) Consultation with parents concerning needs for specific referral to special agencies;
(5) Liaison with local and regional mental health facilities and resources;
(6) Consultation with staff in planning, evaluating, and improving program operation, including curriculum development, and services to children and families."

(Head Start Manual, Office of Economic Opportunity, 1967, p. 39)

To assure compliance with the guidelines, the Head Start Application Form (CAP Form 30b, p. A21, item #29) has a checklist to specify whether each of six functions in the psychological services program is to be performed, and the name of the agency or individual to perform each:

Counseling with Staff and Parents
Participation in Staff Training
Observation of children
Individual testing and diagnosis
Treatment, and
Other.

Finally, the Head Start Manual specifies the minimum and maximum leveling of staffing psychologists according to the size of the program, ranging from at least one part time Director of Psychological Services and psychologist for small programs, a maximum of one psychologist per 200 children. Thus, a program with

3,000 children could have a fulltime Psychological Services Director and 15 Psychologists. With such a level of staffing, and with an injunction against the blanket testing of IQ and achievement, the consultative functions of the psychologist would seem reasonably safeguarded and, indeed, even encouraged. The functions of the psychologist in Head Start, especially as seen in functions (1), (3), and (6), demand that he be responsive to the organization as a whole, and not just a part of the Head Start program. Effective functioning of a particular Head Start organization requires that all of the interrelated elements are performing well both as individual units (e.g., Educational Program, Social Services, etc.) and as members of the team (e.g., Teachers reporting on home visits to the Social Workers, etc.). If the psychologist is to succeed in helping the whole Head Start organization function effectively, then he must be tactful but effective in staff management matters such as correcting overly rigid or authoritarian role prescriptions, replacing low quality staff, initiating staff training, and drawing Head Start parents into meaningful participation with their children. In short, the official structure set down by Head Start in 1967, would seem to encourage psychologists to function at a high level of progressive, effective, and innovative community psychology.

Unfortunately, this has not happened. Indeed, in many cases, there isn't even a psychologist in the program, even on a part time basis. Where there are psychologists in programs, usually they are not familiar with the guidelines, or seem unable to follow them, thus sliding back into the old role of diagnostician-IQ tester, rather than consultant.

What accounts for the disparity between the promise and the reality? The overall program has explicit and implicit organizational rules, construed differently from area to area, city to city, but with a total pattern of what is permissible and what is not. Simply put, it is permissible to wink at the Head

Start requirements for psychological services, and get away with it.

Nevertheless, there are four distinctive patterns of winking which I wish to pursue on an impressionistic level, begging the forgiveness of my colleagues in eye-lid conditioning. Each of the four patterns constitutes a syndrome if we use the metaphor of viewing each Head Start organization as an organism.

The Naive, Overburdened Syndrome

Often, but not always, the Naive Overburdened Syndrome occurs in rural areas where professional consultation of any nature, including educational and medical as well as psychological, is extremely limited. In one of the Naive Overburdened types, Head Start Director spends all his time attempting to secure minimally adequate buildings, food for lunches, and teaching personnel. Thus, he is too overwhelmed with the "necessities" to concern himself with the "luxuries" for the program. Valid as his concern for the welfare of the children may be, such a Head Start Director may literally never have given psychological services a serious thought, not to mention including it in the program narrative of the grant application, or seeking local or out-of-town consultants to provide the services.

The office that directly authorizes the Head Start funding may itself be similarly overburdened with an abundance of work, and a shortage of staff, giving highest priority in their advisory attitudes and refunding behavior to those "necessities" like buildings, food, and teachers, and giving lowest priority to "luxuries" like psychological service. The authorizing office has the theoretical ability to help to compensate for weaknesses in particular programs, by evaluating programs and supplying technical assistance where necessary. However, the inefficiency of the authorizing office may compound the problems of a struggling Head Start program.

For instance, in another of the Naive, Overburdened types, the program had been visited by outside consultants for a year and a half, and no report had been sent to them with suggestions for improvement. On my second visit to this program, which was one month after my first visit, they had not yet received my first report which I had promptly submitted. I repeatedly called the authorizing office, and finally I reached an official responsible for this particular program. Yes, he had received my first report, but "it must have slipped through the cracks in the floor somewhere" because he could no longer find a copy of it.

Thus, in the Naive Overburdened Syndrome, a Head Start program may realize that it needs psychological services (or other) consultation, may ask for services, and may even be visited and promised a report, but no report ever comes. After months and years of lanquishing, the program feels further alienated and is thus less likely to even ask for assistance; if such assistance is provided, it will be viewed with suspicion.

Identifying Characteristics of the Naive, Overburdened Syndrome include:

1. Lack of familiarity with the Head Start Manual.
2. Desperate shortage of adequately trained and experienced key personnel including (besides psychologists) Social Workers, Volunteer and Doctor's, Dentist's, Parent Activities Coordinators, and Supervising Teachers.
3. Poor understanding of basic dimensions of the preschool child's development among the staff.
4. Chaotic administrative organization.
5. Nonexistent communication among the staff on various levels; demoralized staff attitudes.
6. No contact with other agencies.

The Disorganized, Indifferent Syndrome

If programs,which once had vitality of interest and enthusiasm among the staff, have problems which go unsolved due to administrative ineptness

or whatever, the immediate result will be a series of flare-ups. Over a period of months or years, the flare-ups may die down, as those concerned either leave the program or become demoralized. The remaining staff will become detached and indifferent. These attitudes have great survival value for the individual in this situation, but they contribute to, and solidify the disorganization of the program.

A key etiological factor in this syndrome often is a governing board of directors who themselves suffer from the same syndrome of disorganization and indifference. The clash of the interests of the poor in the community, which should be represented on the board, with the interests of the community's dominant power structure may lead to both a stalemate in the conflict and an impotent board that can't make important decisions.

In one such case, a white Director of the parent CAP agency resigned. His logical replacement, the Black Assistant Director, was not acceptable to the Board because in this town, no Black had ever received a salary of $15,000 per year. Though the Board was unable to make this and other important decisions for the welfare of the agency, its individual Board members were exerting much influence over the hiring of Head Start personnel, running completely over the wishes of the Head Start Director as well as others along the way.

In contrast to the Naive, Overburdened Syndrome, where there are no Psychological Services whatsoever, there may or may not be a Psychological Services in the Disorganized, Indifferent Syndrome. If there have been some psychological services, typically it consists of a volunteer or paid consulting psychologist who is called to evaluate a handful of children, typically behavioral problems. Some reports are filed away in the psychologist's office or Head Start Director's office. The child's teacher is left in the dark. The psychologist, if he works at a public child guidance clinic, may have recommended that the child and his family come to the clinic for treatment. When several families don't show up,

the psychologist labels Head Start as hopeless.

The single agency with the most resources for providing psychological services for children is, in most communities, the public school. But the public school usually feels overburdened itself, and is often unable to supply needed support.

In an example of such a program, the Parent Community Action Agency and Head Start had the following characteristics:

1. There was a lack of basic communication between the Head Start central staff and several delegate agencies, which were conducting the Head Start program.

2. There was no mechanism for implementing education practices and policies in the way of in-service training, promotions on a performance basis, overall screening and advisement of daily operations, staff selection and retention, staff performance, priority selection in terms of assigning the budget, etc. There was no coordination of the educational program with the other component programs of Head Start including social services, psychological, medical, dental, etc.

3. In-service training which had been allowed to deteriorate deserved special attention since many of the teachers and teachers aides lack experience and are inadequately trained.

Which had the following implications for the psychological services:

1. The Head Start Director reassigned the titular Psychological Services Director to other duties so that she had no time to perform her psychological services.

2. The Psychological Services Director had neither adequate training or experience.

3. None of the volunteer psychology consultants were familiar with the functions of the Head Start psychologist as described in the Head Start Manual.

4. Community resources had not been used to the extent that they should have.

5. Social services to support and complement an adequate psychological services program were nonexistent.

6. The teachers' home visits and observations of children's behavior, also supportive of a psychological services program, occured only rarely and not systematically as specified by the Head Start Manual.

7. There was no attempt to keep necessary records on the children's progress, or on family or parent contacts.

The University Exploiter

Since universities frequently, and sometimes unfairly, are criticized for exploiting problems or programs in the ghetto, I am reluctant to furnish more ammunition for the critics. However, I have seen classical exploitation by some universities and by some psychologists in them. For instance, one university based psychological consultant provided "I.Q." scores for all Head Start children which a Head Start Director posted (with names) on his office walls. Any use of a blanket IQ testing procedure is highly suspect, even where the test is a standard one, and the results are kept confidential. However, Head Start forbids even this practice. In this case, the I.Q. scores were derived from the Bender-Gestalt Test, a highly questionable procedure. Thus, this psychologist violated a Head Start directive and two principles of the American Psychological Association's Ethical Standards (Principle 2. Competence, and Principle 14. Test Interpretation)

A second example of university exploitation is in the area of training. In one program a number of psychology graduate students worked with Head Start children identified as having a behavioral problem such as thumbsucking. The students apparently used operant techniques with, at best, mixed results. Neither the students nor their professor submitted any written report. There was little service involved, but most disturbingly, the students did not seem to have any supervision.

Thirdly, Dr. "X", a white university-based "psychological consultant," had no training or background in psychology, but rather in a specialty of education. He wa quite frank in stating that he was interested in the local Head Start program, which Black, to control the curriculum. Dr. "X" hoped to unseat the Director. When pinne

down as to how he would function as a psychologist, he said, "I'd like to do a lot of coordination...speech and hearing and that kind of thing." He was not acquainted with the functions of Psychology listed in the Head Start Manual.

At an official meeting of this Head Start program, a young lady was introduced as "Dr. X's Representative in Psychology." Like Dr. X, she had no real background in psychology. Her field was preschool education. By feigning as a Psychologist, she and Dr. "X" hoped to move in the side door and take over Head Start.

Finally, when Dr. "X" hurriedly resigned as psychological consultant, he recommended in his place a clinical psychology student who lost his fellowship because of poor grades. By recommending an inferior person to Head Start, Dr. "X" also revealed a disregard for the program, its goals, and a subtle, though distinctly racist attitude.

Sophisticated Slicker and Bureaucratic Zombie

The last syndrome is often seen as one composite syndrome, though each of its subsyndromes may be observed separately. For instance, I last saw the Bureaucratic Zombie in a pure form, without pretense or psychopathic cover-up, exposing its dynamics, which were a classic vicious circle: Bureaucracy led to poor morale among the staff, the poor morale led to a poor program, and the poor program led to more bureacracy. For instance, the teachers were required to complete 10 different forms each week or month. The forms, including a 15-page children's observation record, reduced staff morale, time, and effectiveness. In another example, teachers were strictly required to make monthly home visits and fill out a form on each. Consequently, the home visits were brief, perfunctory, and devoid of meaning or purpose.

Psychological services in such a setting were prostituted. Referrals for

evaluation were made to agencies whose reports were so deficient as to be unethical. The evaluations were used to remove the children from the Head Start program, rather than to adjust to the classroom situation.

In summary, identifying characteristic's of Bureaucratic Zombie include:

1. Compliance with official program requirements are present on paper, not in actuality.

2. Highest priorities are always given to the administrative procedures, and thus child development concepts are often lost in the shuffle. Some super powerful administrative organizations and sub-organizations resemble military-type organizations. The resemblance is not merely coincidental.

3. In the rigidly authoritarian hierarchies, communication proceeds in one direction only, from the top down. No complaints or suggestions for improvement are allowed to filter up to the Head Start Director.

4. The staff attitudes at the level of teachers and teacher-aides are thoroughly demoralized and/or indifferent.

5. Since such great investment is made in <u>their</u> organization, contact with any outside agencies, individuals or volunteers, who may be able to help further the Head Start program, is viewed with suspicion or hostility. Therefore, there is no meaningful collaboration with potential community resources.

Finally, the Sophisticated Slicker syndrome, usually found in larger cities, is frequently a part of the Bureaucratic Zombie syndrome. That is, the Sophisticated Slicker says, "Everything is fine with us. See we've complied with all regulations, and we're doing a <u>great</u> job." Like every well integrated psychopath, the Sophisticated Slicker has indeed complied with official procedures, at least superficially, <u>or</u> has a ready alibi prepared.

As a kind of psychopathic overlay to conceal program deficits, the Sophisticated Slicker usually also combines with the University Exploiter, and less frequently with the Disorganized, Indifferent Syndrome. When psychopathic features are present, differential diagnoses among Head Start or organizational pathologies may be difficult to establish, as is true in the case of indiviual psychopathologies.

If I haven't already stretched the analogy too far, I wish to make one last comparison between organizational and individual disorders. A good understanding of the nature of the disorder, and its underlying etiology if possible, would facilitate treatment or remediation. That is, there are significant differences in the course of effective action to correct deficits in Head Start psychological services, depending on whether the program has a Naive, Overburdened Syndrome, or something else.

Situations Common to All Programs

However, there are certain weaknesses or deficits in Head Start that are common to all the programs I have seen. The problems shared by all programs lie mainly in the central directing structure.

1. Programs are annually handicapped by the unfortunate funding procedures by OEO and, ultimately, Congress. As a result, funds for psychological services may not be available until a given year is over.
2. The selection of priorities appears questionable, raising the whole process of priority selection, which is tied to the whole realm of the community's "maximum feasible participation."
3. The Head Start staff's efforts are diminished through a combination of the lack of delegation of authority and the lack of organization across services. Although, the individuals may be sincerely dedicated to producing a good program, and there may be no apparent barriers to communication, there seems to be a lack of true working relationships at practically all levels.
4. The efforts of consultants have been diminished by a basic lack of communication and coordination between Head Start Regional Offices and the local programs. OEO lacked an effective mechanism to enforce

compliance with its policies and directives. The only mechanism available, cutting off funds or threatening to, has been ineffective because it was so drastic it was rarely if ever used.

Specific agency-wide changes are obviously needed. My recommendation would be that:

1. The Head Start structure, especially from the Regional Office to the local Head Start program, should be tightened up drastically, in order to put muscle into the recommendations that are made.
   a. The Field Representative, Regional Training Officer, and consultants should confer together in person at regular intervals.
   b. New lines of authority should be articulated in order to make the Head Start Programs more responsive to Head Start guidelines.
2. The members of the local community governing boards should be better informed of the extent and limitations of their duties and responsibilities to promote the functioning of the Head Start program.

IV. Psychological Services in Head Start: Some Promising Models

A. Psychological Consultation for Head Start Staff in Small Groups.

The following model of Head Start Psychological Consultation is recommended to correct the problems in delivering psychological services that are generally encountered, and to keep the Head Start and Education Directors in close touch with their centers in terms of meaningful center-level problems and in-service training. Therefore, there would be an available vehicle for interdisciplinary communication that would make possible or enhance the delivery of medical, social services, psychological, and other services. Such a vehicle--a regular series of small meetings or conferences--is needed to allow the Head Start Program benefit from psychological services in particular, but it would also be an

important addition to all aspects of the program.

There should be internal organization within Head Start to enhance the intra-organizational communication, permitting it to make good use of psychological consultation. There should be regular Center (or Area) Work Conferences that might be arranged as follows:

Organization. 1. Natural geographical units should be determined for maximum cooperation and communication, either at the Area or the Center level. All Center Directors, Teachers and Teacher-Aides should participate in groups from a minimum of 10 or so to a maximum of 15 or 20 participants.

2. The Work Conferences should be held regularly, every two weeks, or every week, depending on circumstances and objectives.

3. Every Work Conference should have a decidedly professional orientation with at least a representative from the Head Start central staff in Education or Social Services, and preferably from both. One of these professions should chair each conference, except when it would be more appropriate to have it chaired by the Psychological Consultant or Psychologist.

4. The Psychological Consultant or Psychologist should attend at least one meeting per month.

Objectives. 1. The main purpose of the Work Conference would be to focus on an individual child's development with contributions from all staff who have any contact with the child or his family: the Teacher, Teacher Aide, and Volunteer who work with him on an everyday basis; the Social Service Aide who has made home visits and is acquainted with the child's family; and whoever else has relevant information to contribute, e.g., the Nurse, the Speech Therapist, etc. These Conferences would of course spend more time on children who are presenting unusual behavior or some other problem. Not only diagnostic referrals would be

made, but special, individualized approaches to working with the children would be formulated. At this time, a Work Conference would:

a. Describe the child and his family as fully as possible.
b. Describe what strategies the staff has already tried in dealing with the situation.
c. Evaluate the results of these strategies.
d. Determine whether to continue the same course, or plan a new course of action for out the child's fullest potentials.

During the intervening period between the work Conferences, the Teacher and others would have an opportunity to implement the new approach at working with the child. At subsequent Conferences, then, there would be reports of progress or lack of progress with the new approach.

2. The Work Conference would also be a good vehicle for continued In-Service Training, but on a limited basis (no more than once or twice a month during these times).

Referrals. Children in need of individual diagnostic evaluations would be referred to local agencies. Discussion of the need for referral, the arrangement of the evaluation, and the follow-up on the evaluation, would be the Psychological Consultant's primary tasks; (see the Head Start Manual, page 39).

B. Head Start Parent Meetings Using Participant Group Methods

To cope with the almost universal failure to meaningfully engage Head Start parents in programs, new methods must be tried. The participant small group method has proven successful in an initial pilot effort (Wohlford & Stern, 1968), and on a larger scale (Wohlford, 1970).

Objectives. The purpose of this method is to intervene in the poverty cycle by changing attitudes and behavior among parents of preschool children. These changes in parental attitudes and behavior are intended to promote beneficial social interactions within families by (1) improving the parents' own emotional and cognitive functioning, and (2) helping the parents to assist their children's

emotional and cognitive development.

Procedures in an initial project. The intervention technique was a participant, small group method that is a modification of the sensitivity training laboratory method. Eight different series of groups were conducted, systematically varying the membership, duration, and content of the group. One hundred Head Start families were recruited and participated in samll groups of 10 to 15 parents for a two-month period. The parents were encouraged to participate actively by having the groups small enough to allow participation, having the meetings in the evenings twice a week, having skilled group trainers to help them, providing materials for their children's language development, and paying the parents five dollars per meeting for their time. Although our evaluation of this method is not finished, our impression is that the method was quite successful in gaining regular attendance at the meetings and enthusiastic involvement in the meetings themselves

V. Conclusion

In summary, when the psychologist serves Head Start, he must be more than a clinical child psychologist attending to individual children with specific problems, and more than a child psychologist attending to the developmental situations of groups of children. He must be a consultant to the Head Start program in the manner that Glidewell (1966) and others have described. This means the psychologist must attend to the whole Head Start organization, from top to bottom, Director to children, and horizontally from potentially supportive agencies in the community, to the Head Start staff, to the children and their parents. In the process of serving as a community psychologist, he will be called on to perform traditional clinical services, as well, as Spaulder (1969) described.

Not all psychologists will like these splits in roles, and splits in different responsibilities to different agencies and individuals who are often themselves in conflict. Yet, if we do not now have enough psychologists who are willing to accept these new roles and responsibilities, we must train psychologists who are. As I see it, that is the greatest challenge of this new direction in clinical child psychology.

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